

9590

## CERTIFICATE OF DEATH

Reg. Dist. No. 600

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Goldsboro</u>		<u>79 Yrs.</u>		TOWN <u>Rural Goldsboro</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>William Eldridge Carney</u>				OF DEATH: <u>10</u> <u>5</u> <u>55</u> <u>19</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH: <u>3/23/1876</u>	
9. AGE last birthday: <u>79</u> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William H. Carney</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Mathews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Ray Carney Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Thrombosis</u>				<u>Sudden</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 5</u> , 19 <u>55</u> , to <u>Oct. 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>55</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Stinesinger</u>		ADDRESS <u>Greenboro, Md.</u>		DATE SIGNED <u>Oct. 6, 1955</u>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Rural Goldsboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/8/55</u>		REGISTRAR'S SIGNATURE <u>actsmith</u>		24. FUNERAL DIRECTOR <u>J. E. Boulais</u>		ADDRESS <u>Greenboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

NOV 14 1955

RECEIVED

4 3 1955

MARYLAND STATE DEPARTMENT OF HEALTH

09596

9591

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. *60*

1. PLACE OF DEATH- COUNTY <i>Caroline</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Marydel</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Marydel</i> <i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>		STREET ADDRESS (If rural, give location) <i>None</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Maud</i>	(Middle) <i>Temple</i>	(Last) <i>Hummer</i>
4. DATE OF DEATH	(Month) <i>10</i>	(Day) <i>25</i>	(Year) <i>55</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>6/9/1884</i>
9. AGE last birthday <i>71</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired School Teacher</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>L.N. Hummer</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Barton Temple</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT AND ADDRESS <i>James L. Hummer Frankford, Del.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>few minutes</i>	
(a) <i>Immediate cause</i> <i>Coronary occlusion</i>			
(b) <i>Antecedent cause(s)</i> <i>Hypertension</i>		<i>5 yrs</i>	
(c) <i>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>Dawson George M.D. Deputy Medical Examiner</i>		DATE SIGNED <i>10/28/55</i>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <i>10/29/55</i>	NAME OF CEMETERY OR CREMATORY <i>Templeville</i>	LOCATION (City, town, or county) (State) <i>Templeville, Md.</i>
DATE REC'D BY LOCAL REG. <i>10/29/55</i>	REGISTRAR'S SIGNATURE <i>A. C. Smith</i>	24. FUNERAL DIRECTOR <i>J. E. Boules Greensboro, Md.</i>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. 09592

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Federalsburg</u>		<u>24</u> years		TOWN <u>Federalsburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hurlock Road</u>				STREET ADDRESS (If rural, give location) <u>Hurlock Road</u>			
3. NAME OF DECEASED: (First) <u>Harold</u>		(Middle) <u>Clifford</u>		(Last) <u>Layton</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>22</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 18, 1896</u>	9. AGE last birthday: <u>59</u> yrs.	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Melvin Layton</u>				14. MOTHER'S MAIDEN NAME: <u>Edith Lowe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No.: <u>218-34-9174</u>		17. INFORMANT & ADDRESS: <u>Mrs. Edna C. Layton, Federa lsburg, Md.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>Hypertension</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Arterio-sclerosis</u>						<u>2 hrs</u>  <u>2 hrs</u>  <u>  </u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc. INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Sawson D. George</u>		M. D. <u>  </u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/24/55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Oct. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct 24 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS <u>  </u>	

BUREAU V. 2

OCT 29 1955

RECEIVED



Item 2, Film 11-3-55 et

9593

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Greensboro-Rural</u>	LENGTH OF STAY (in this place) <u>17 mon.</u>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Federalsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cherry Nursing Home Greensboro, Maryland</u>		STREET ADDRESS <u>North Main Street Cherry Nursing Home</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Margaret</u>	(Middle) <u>Jennings</u>	(Last) <u>Noble</u>	(Day) <u>16</u> (Month) <u>October</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan. 14, 1882</u>
9. AGE last birthday: <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>A. L. Jennings</u>		14. MOTHER'S MAIDEN NAME: <u>Kate Mowbray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-22-9495</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Dale Elrick- Federalsburg, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE (B) <u>Cerebral General Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 5, 1954</u> to <u>Oct. 16, 1955</u> , that I last saw the deceased alive on <u>Oct. 15, 1955</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles A. Staecker</u>		DATE SIGNED <u>10/17/55</u>	
ADDRESS <u>M. O. Greensboro, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. J. Frampton and Son, Federalsburg, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/17/55</u>		REGISTRAR'S SIGNATURE <u>L. Mae Pepin</u>	

MARGIN RESERVED FOR BINDING

V.S. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 31 1955

RECEIVED



9594

09599

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. *62*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hillsboro</i>		CITY (If outside corporate limits write RURAL and give nearest town) <i>Rural Hillsboro</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
<i>ARLEY (First) (Middle) (Last) PINKNEY</i>		<i>Oct 24, 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>M</i>	<i>E</i>	<i>Single</i>	<i>unknown</i>
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	
<i>68 yrs.</i>		<i>helper</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Charles Pinkney</i>		<i>Mary Banks</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<i>no</i>		<i>Reggie Pinkney, Queen Anne, Md</i>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<p><i>431X</i>          Immediate cause (a) <i>Mysocarditis acute</i>          DUE TO <i>Exhaustion</i></p> <p>Antecedent cause(s) (b) <i>Exhaustion</i>          Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>		
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *Damon D. George* CHIEF MEDICAL EXAMINER ☐ DATE SIGNED *10/27/56*  
 M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Buried</i>	<i>Oct. 27, 1955</i>	<i>Sandtown</i>	<i>Hillsboro, Md</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<i>10/27/55</i>	<i>Damon D. George</i>	<i>J. Virgil Moore, Son, Denton</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

2-18-74

2-18-74

RECEIVED  
FEB 18 1974  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

RECEIVED  
FEB 18 1974  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

DEC 31 1973

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189600  
9595 CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Federalsburg</u>	LENGTH OF STAY (in this place) <u>69 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>301 Buena Vista Avenue</u>		STREET ADDRESS (If rural give location) <u>301 Buena Vista Avenue</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>John</u>	(Middle) <u>Warren</u>	(Last) <u>Stowell</u>	<u>October 5 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>June 4, 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Williamsport, Pa.</u>	
11. BIRTHPLACE (State or foreign country): <u>Williamsport, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry F. Stowell</u>		14. MOTHER'S MAIDEN NAME: <u>Annie Hurr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-8561</u>	
17. INFORMANT & ADDRESS: <u>John W. Stowell, Jr., Federalsburg, Md.</u>			
15. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			<u>1 hr.</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Hypertension</u>			<u>Sys.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/5</u> , 19 <u>55</u> , to <u>10/5</u> 19 <u>55</u> that I last saw the deceased alive on <u>10/5</u> , 19 <u>55</u> and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. M. Anderson</u>		M. D. <u>Federalsburg, Md.</u> DATE SIGNED <u>Oct. 6, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 8, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>October 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret N. Frampton</u>	
24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

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